Crossways Camping Ministry Day Camp
Health History Form

This form needs to be completely filled out by a parent/guardian.

Name_____ □ Male □ Female Age____ Grade Completed _____
last first

Parent or Guardian _____ Home Phone: (_____)_____

Home Address_____ Work Phone: (_____)_____

In an emergency, if parent/guardian not available, notify_____ Relationship _____

Home Phone: (_____)_____ Alternate Phone: (_____)_____

Health Insurance Carrier_____ Group/policy number_____

Name of physician _____ Phone number _____

Health History

Please check and date any of the following, which have occurred to the camper or in the camper's family:

Conditions	Diseases	Allergies
____ Frequent ear infections	____ Chicken pox	____ Hay Fever
____ Heart disease/defect	____ Measles	____ Ivy Poisoning, etc.
____ Convulsions/seizures	____ German Measles	____ Insect Stings
____ Diabetes	____ Mumps	____ Penicillin
____ Bleeding/clotting disorders		____ Other drugs _____
____ Hypertension		____ Asthma
____ Mononucleosis		____ Other: _____
____ Psychiatric counseling		

Please explain any of those checked above:
_____

Operations or serious injuries: (please list with dates) _____

Suggestions, any activity restrictions, or health-related information for camp personnel:
_____

Current medications: Give name, dose, and schedule (medication must be brought in original labeled prescription bottle)

_____

Please explain conditions requiring medication or other conditions requiring special care:_____
_____

Medical-Surgical Release: My child has permission to take part in all day camp activities including offsite activities under supervision and I agree that Crossways Camping Ministries and the applicable congregation, or their personnel, will not be held responsible for accidents or personal injury arising there from. If my child should require EMERGENCY medical treatment during Day Camp with Crossways Camping Ministries and my emergency contact and I cannot be reached, I hereby give permission to the Congregational Coordinator and/or Camp Coordinator to arrange necessary transportation and to secure proper treatment. The selected physician or medical personnel has/have my permission to hospitalize, to order injection, anesthesia, x-ray or surgery for my child, as named above. I further authorize the staff of Crossways Camping Ministries and/or the Congregational Coordinator to administer over the counter drugs and medications as needed. I certify that my child is *not allergic to any non-prescription medications not listed above*. I understand that Crossways does not provide medical insurance.

I also consent to the use of any photography and/or video of my child in current or future Crossways Camping Ministries publications/presentations.

Parent/Guardian Signature_____ Date_____

Signature of witness_____ Date_____

Staff Use Only
Form Signed? Y N Camper healthy today? Y N Medication to be taken at DC? Y N Medication collected? Y N
Medication Schedule noted? Y N Any allergies? To food, medication, bee stings, etc? Y N Allergies listed above. Y N